Administration for Community Living
Affordable Care Act Webinar
Promising Practices for Medicaid Managed Long Term Services and Supports
January 29, 2013
3:30-5:00 pm Eastern

Coordinator: Welcome and thank you for standing by. At this time all participants are in a listen-only mode. After the presentation there will be a question-and-answer session. To ask a question at that time please press star-1 on your touchtone phone. Please unmute your phone and record your name at the prompt.

This conference is being recorded. If you have any objections you may disconnect at this time. I would now like to turn the meeting over to Ms. Marisa Scala-Foley. Go ahead, ma'am, you may begin.

Marisa Scala-Foley: All right, thank you so much, Operator. Good afternoon everyone, good morning to those of you who are on the West Coast. As the Operator mentioned, my name is Marisa Scala-Foley. I work in the Office of Policy Analysis and Development in the Center for Disability and Aging Policy at the Administration for Community Living.

We do thank you for joining us for this month's webinar which is our latest in now a two-plus year long webinar series focused on the patient protection in Affordable Care Act, also known as the Affordable Care Act or ACA and its impact on older adults, persons with disabilities, and aging and disability organizations.

Our webinar series is designed to provide aging and disability organizations with the tools that you need to participate in ACA related efforts in your area such as Accountable Care Organizations, state integration for dual eligibles, health homes, managed long-term services and supports, and more.

Today we continue our multi webinar series that we began last year on - that focuses on integrated care and managed long term services and supports. As an increasing number of states move toward developing and implementing managed long term services and support for older adults and people with disabilities there are lessons to be learned from states that have already made this transition and in some cases have been doing this for decades.

So today we will examine promising practices for managed long term services and supports from states with existing programs. And all of this is discussed in a report that was put out by Community Catalyst called *Putting Consumers First: Promising Practices for Medicaid Managed Long Term Services and Supports*.

Before I introduce our speaker we do have a couple of housekeeping announcements. First of all, if you have not yet done so please do use the link included in your email confirmation to get on to WebEx so you can follow along with the slides as we go through them and also ask your questions when you have them through the chat function in WebEx.

If you don't have access to the link we emailed you you can also go to www.WebEx.com, click on the attend a meeting button at the top of the page, and enter our meeting number which is 668532713. Again, that meeting number is 668532713. And that pass code is ACLWEBINAR, all one word and all in caps, and that's ACLWEBINAR.

If you have any problems getting into WebEx please contact WebEx technical support at 1-866-569-3239, again that technical support number at WebEx is 1-866-569-3239.

As the Operator mentioned, all participants are in listen-only mode. However, we do welcome your questions throughout the course of the webinar. There are two ways you can ask your questions. Throughout most of the webinar you will need to ask your questions through the chat function in WebEx.

You can enter your questions and we will sort through them and answer them the best we can when we take breaks for questions throughout - during the webinar.

In addition, after Alice wraps up we will offer you a chance to ask your questions through the audio lines. When that time comes the Operator will give you instructions as to how to queue up to ask your questions.

And always, if you think of any questions after the webinar or if there are any questions that you'd like us to follow up on that we weren't able to answer during the course of the webinar, you can email them to us at AffordableCareAct@AOA.HHS.gov. Again, that's AffordableCareAct@AOA.HHS.gov.

And because we tend to get this question a lot, just a reminder, you cannot print the slides through WebEx. We will post them on our website within hopefully a week or so after this webinar. But if you would like the slides in advance you can email us, again at the same email address, AffordableCareAct@AOA.HHS.gov.

As the Operator mentioned, we are recording this webinar. The recording along with the slides and the transcript, as I mentioned, will be posted on our website as soon as possible.

So with housekeeping now out of the way we are thrilled to be joined today by the author of the Community Catalyst report I referenced earlier, *Putting Consumers First: Promising Practices for Medicaid Managed Long Term Services and Support*.

Alice Dembner leads Community Catalyst's work in the key areas of Medicaid managed care and long term services and supports and also directs the Substance Use Disorders Project, that collective work seeks to improve the access to quality, affordable healthcare and social supports for vulnerable people by reforming our healthcare system through direct advocacy in Washington and technical assistance to state organizations nationwide.

Alice's background is in investigative and analytic journalism. During 30 years as a reporter and editor she informed policymakers, influenced public opinion, and spurred change. She won national awards for her health coverage at the Boston Globe which focused on gaps in care for the uninsured, seniors, and children with mental illness.

And I should also mention, I think Alice will talk about this as well, but Community Catalyst is a national non-profit advocacy organization working to build consumer participation in the healthcare system.

So with that I will turn things over to Alice to start the substance of our webinar.

Alice Dembner: Thank you so much, Marisa. And good afternoon all or good morning. So as Marisa mentioned, I'll be tackling the subject of promising practices in Medicaid managed long term services and support from the consumer perspective, that is how can we make these programs work best for consumers.

Next slide, please. So as Marisa told you, Community Catalyst is a national organization. We're based in Boston.

And next slide, I'll tell you a little bit more about us. So our goal is high quality affordable healthcare for all. And we work toward that goal in a number of ways. One is through issue campaigns to achieve public policy changes.

And we have worked extensively on the Affordable Care Act. We also worked on the reauthorization of the Children's Health Insurance Program. And currently we're working on programs that try to expand the practice of dentistry through dental therapists as well as working on hospital community benefits.

We also work to shape new models of care and those include working on models of integrated care including the demonstrations that the federal government is running through the Affordable Care Act for people who are eligible for both Medicaid and Medicare, the dual eligibles.

As well as the changes in Medicaid, for example, Medicaid long term services and supports going to managed care.

We also work with advocates in states across the country and these are mostly state-based consumer advocates who are addressing the issues that are most

critical in their communities. And we provide technical assistance to them to help them do their work better.

Running through all our work is a focus on collaboration, which we believe is the most productive way to move social issues forward.

Next slide, please. So today I'll be covering these areas; the growth of Medicaid managed long term services and supports; the benefits and risk of that switch; promising practices; and avenues for consumer engagement.

And I hope what you take away will be an understanding of the opportunity that managed Medicaid long term services and supports presents for better care and control of costs. And of the need of collaboration with stakeholders, particularly consumers, in shaping and overseeing the program.

Next slide. So Medicaid managed care is growing like crazy. A few years ago there were only a few states that were doing this and the estimates are that by next year about half of states will have shifted from fee for service programs to managed care for some or all of their long term services and supports.

And I want to credit Truven Health Analytics and the Centers for Medicare & Medicaid Services for this map, which is included in a report that I believe is in the resources at the end of this slide deck. The map shows in the dark blue color, those states that were doing managed care in 2012 for long term services.

And in the blue, those new states that were going to move in this direction by 2014. And in the magenta, those that were doing it and are going to be doing more or doing it differently. So we're looking at a big shift.

And today we're going to focus on capitated managed care in which states hire a managed company to run the program and that company assumes the financial risk or most of the risk of caring for people.

We will not be looking at other forms of managed care such as primary care case management or the pace programs, both of those are good programs but they're not our focus today.

Next slide. So what are the driving factors behind this shift? First of all, there's certainly rising demand for these services as the population ages and as more people are living longer with complex disabilities.

Costs, I would say, may be the biggest driver for states. This is about one-third of their Medicaid spending. But according to the most recent statistics, which are from 2009, only about 5% of that spending was in a capitated managed care system.

There are also many failures of the fee for service system that are driving this change. Those include fragmented care, uneven quality, and even failing to keep people healthy.

The demand for community-based care is also a factor here for shifting care from our nursing homes to home and community-based settings. This is both required by the Americans with Disabilities Act as well as what consumers are - you know, they want and are more and more demanding.

And finally, there are federal incentives and federal flexibility that have come through the Affordable Care Act and through other means. So there are expanded options for state plans and for waivers. There is the demonstration for dual eligibles that I already mentioned. And there are also Affordable Care

Act incentives to rebalance that care from nursing homes to the community settings.

Next slide. So is the shift positive or negative? Let's take a closer look. So on the benefits side, I would argue that the potential benefit is better care with an ability to control costs. And that would come from, one, expanded access would be a way to improve care.

A number of states have used their managed care programs to expand - particularly home and community-based services and to eliminate waiting lists. And Hawaii and Wisconsin are two states which did use their managed care programs to eliminate the wait list. I must say, Wisconsin has reinstated their wait list unfortunately.

Also, states are adding services, for example, Delaware recently made the switch to managed care in this sphere and added services including home modifications, homemaking, and home delivered meals that had not previously been benefits in this program.

States may also find that they are able to rebalance more easily. Tennessee has made no secret that managed care has helped it overcome strong nursing home opposition initially to rebalancing and shifting care to the community setting.

Also, there's the opportunity to improve quality and coordination to address the fragmentation that occurred in the - occurs in the fee for service system. And this is the improvement in coordination comes particularly when there is an integration of medical care and long term services.

And one example there, a place where there really has been a significant reduction in avoidable hospitalization is in the Senior Care Options program

in Massachusetts which really - there have been studies that have been shown that by - really providing people care earlier, they have been able to reduce that hospitalization and reduce also some use of nursing homes.

And finally, some possible improvements in efficiency through stabilization of costs or at least making the costs more predictable. Some states have said that they've actually been able to save money through their systems, Texas said they have saved money on acute care because of going to managed long term services. And Wisconsin Family Care said they saw savings through a reduce of nursing home use.

But I would caution that, many states have not saved money without restricting services or hurting consumers. So if they had saved it's come at some cost. So this is one of the reasons I think that there are cautions and we'll get to some of the other risks in a moment.

Next slide, please. So I wanted to share with you during the course of the presentation a couple of stories of real people just to ground us in what we're talking about here. And this is a story about really how managed care can be a success for consumers. This story comes from a report that governing magazine online did about this shift in care.

So this is a story about Delores who is 86 years old and had had a long active life, was beginning to develop a number of different illnesses including diabetes and dementia. And she was juggling about a dozen medications for those conditions while living at home in Tennessee.

And one day while juggling she dropped a few balls and she ended up in the hospital from a problem with her medications.

So once she was getting better doctors said, you know, they didn't really feel comfortable sending her home to the same situation that she was in, that she needed supervision for the day - for every day, and that they sought two options for her. One was to go to a nursing home and the second was to have all day supervision at home.

Well, neither her son or her daughter-in-law could quit their jobs and stay home with her so they really felt like the only thing open to them was a nursing home.

So Delores went to live quite unhappily in a nursing home that was paid by Tennessee's Medicare program called - Medicaid program called TennCare. So, you know, her family sadly watched as they saw her decline as sort of year after year went by.

And then Tennessee began to implement its Choices managed long term services and supports program and Delores' life took a much better turn.

Choices worked with Delores and her family to set up a care plan to get her home and putting together the services she needed, which included primary care and then a registered nurse that comes to check on her at home once a week, PT at home twice a week initially and then externally, and more importantly, an aide from 7:00 to 5:00 daily.

So Delores now is actually getting out for walks. She's going to her hair salon again. She's visiting with neighbors. And in short she feels that she's got her life back.

Next slide, please. But unfortunately managed long term services isn't always such a success story. There are many for-profit companies who are seeing this

as a great new billion-dollar market in which they can operate. And they make money through efficiency which could be great, but they also may make it through cutting back or cutting services.

And at the same time, many states are setting savings targets for these programs before they even start enrolling people and see how they're going to work out.

So the results can possibly service gaps, growing wait lists, poor quality care, virtually the opposite of giving people the opportunity to live with dignity and as much independence and community participation as possible, which we would hope would be the goal.

Another risk is to community providers who have a long - been working in the long term care market and that they would be squeezed out by larger systems of providers. And then consumers then forced to shift from those providers to strangers to them.

Problems could also result from lack of knowledge among Medicaid officials and MCOs about how long term services are different from acute care.

Also the programs may reduce consumer directed care or person-centered services in a misguided attempt to exert control.

And finally, state and Medicaid staff may be stretched too thin to provide proper oversight. After all, they may be juggling ACA implementation and various innovations while also trying to manage existing programs all while the governors and lawmakers in their state are clamoring for budget reductions. So it can be a problematic mix.

Next slide, please. So how can we ensure better outcomes? I pulled together a set of promising practices that can perhaps help minimize the risks and maximize the benefits.

And doing this I've drawn on the many resources and papers that others have done that have looked at the states currently managed long term services and supports. As well I've drawn on conversations with experts and on the experiences of consumers and consumer advocates.

Some of the resources that have helped to inform the paper that I've written and this presentation are included in the list at the end of this presentation.

And you can find the full list in the endnotes of my paper, which is also in those resources at the bottom - at the end of the presentation. I'll also be citing during the presentation some states that are implementing these promising practices.

With programs constantly evolving I'm sure that I'm not presenting a complete list of the best practices or promising practices. So during the Q&A period it would be great to hear from those of you on the call about other examples as well as new developments.

Next slide, please. So we'll start with promising practices and designing a Medicaid managed long term services program.

Next slide. So from the start it's essential to engage consumers and consumer advocates in planning the shift to managed Medicaid long term services and supports. Consumers and our advocates bring crucial experience in what is needed and what works. And I would argue that the states' first step should be to develop a plan for consumer and stakeholder involvement.

And it's important for this involvement to continue through implementation, through operations, and through the oversight phase as well.

So what does this mean? So again, we would recommend starting with a creation of a state oversight planning council that is at least 50% consumers and their advocates.

Massachusetts in its dual demonstration has established just such a council with very broad responsibility.

States can then add on other ways for consumer engagement including focus groups, surveys, taskforces, and open community meetings. You need a variety of these kinds of methods to really gather broad input and to build support for the change.

Health plans also need this consumer perspective to help inform their decisions. States should require each managed care company to have a robust plan for consumer engagement. We suggest requiring the plans to have at least 25% consumers on their boards and the Wisconsin Family Care program is one example of having that requirement and how it works.

An alternative, though I would argue perhaps not as useful, is having a designated consumer advisory committee with direct access to the plan's top officials.

A number of states are moving in this direction of having either consumer advisory committees or consumers on broader stakeholder committees. Unfortunately advocates tell us that these requirements are not always enforced and that some officials are not as attentive as one would like.

For these boards and committees to work a few steps are really critical. Meetings must be physically accessible and linguistically and culturally appropriate. For example, community meetings should be held in the language that is spoken in the particular community you're in.

States and plans should also provide staff for these communities and stipends for time and travel to make member participation possible. And in cases sounds like an impossible task, there actually is precedent for this kind of support for committees. The regulations for Medicaid medical care advisory committees in fact require this kind of stipend if necessary to ensure consumer engagement.

Next slide, please. So all the changes required to set up a program are not ones that can be thrown together quickly. CMS, in fact, we recommend a two-year process for implementing managed long term services and supports.

Tennessee took three years securing buy-in from stakeholders, working with health plans, and ensuring that everything was ready before they began.

Hawaii was also very deliberate as well although there it took a consumer push to get an advisory committee established that turned out to be very critical in shaping the program.

The focus of planning and the focus of the program need to be person-centered maximizing the consumer's control, choice, and independence. And listening to the needs of those who will be served.

And states need to bring in the experience of those who know long term services and support, which may include the state's office on Aging and Disabilities and those who've been involved in waiver services.

Assessing managed care readiness is also required - the readiness that is of the companies that is required by CMS. And within these review it's really important to pay careful attention to the extent and quality of the LTSS experience of these plans and to make sure that they're ready for the task.

Medical loss ratios are another tool that can be used in planning and - for these plans. They're not as common as we think they should be in Medicaid managed care but states are moving in this direction.

Ohio and its dual demonstration has set a 90% medical loss ratio per plans. And just to clarify what that is, that means that 90% of the capitated payment that the MCOs receiving must be spent on acute services as opposed to overhead or profit.

And so in Ohio, if the plans fall below that level the rules that are being set up would have them face a fine and perhaps requirement that they forfeit revenue to Medicaid and Medicare that they would otherwise be able to pocket.

Next slide. So one key aspect of planning is setting up mechanisms to ensure that needed services are provided quickly. I offer an example of what we want to see avoided. And this is provided for advocates in one of the states that has gone to managed care for long term services.

So Julio is an 87-year-old who lives alone and has difficulty walking and also some cognitive impairment. Under a waiver program he was getting six hours of home care a day but it wasn't enough. His daughter was staying with him

overnight whenever she could but given her other responsibilities she was burning out.

When his state switched to mandatory managed care he was assessed and the state authorized 24-hour care. He and his family were really relieved. But then a month ticked by without any change. Three months later he's still waiting, caught in a snafu about how people in a waiver program are transferred into the new managed care program. These are issues that need to be worked out in advanced.

Next slide, please. So another step in planning is deciding how the managed care will be structured. At Community Catalyst we believe strongly that integration of long term services with other services is really key to providing the greatest benefit to consumers and also the great efficiency.

Arizona, Massachusetts in its Senior Care Options program, and Tennessee are among the states that have integrated their managed long term services with acute and behavioral services. Most of the dual demonstrations are also moving in this direction.

An alternative that can work is for the state to require the long term services plan to serve as the overall care coordinator. New York in its voluntary managed long term care program, which is now being superseded by a mandatory program, had followed that model.

And Wisconsin Family Care does - currently require plans to coordinate with other Medicaid services and to serve in that function.

Next slide, please. How the state handles enrollment is a critical factor. We believe strongly that voluntary enrollment where consumers most actively -

must actively opt in is the best way to ensure consumer needs. Because the plans really have to be attractive enough in this case to bring in consumers.

Both Minnesota and Wisconsin have showed that this can work. Minnesota is in its long running senior health options, has enrolled 36,000 members, about two-thirds of those eligible. And Wisconsin Family Care enrolls about 33,000.

A second, in our opinion less desirable option, is one in which consumers may have a period to choose a plan but then are automatically enrolled if they have not chosen.

In this option often called passive enrollment the consumer retains the right to opt out. A number of states are using this option, particularly for the dual eligible population.

Finally, many states are mandating enrollment with no allowance for opting out. And we believe this model is most likely to fail in serving consumer needs.

For all of these options, but especially for the passive and mandatory options, we believe additional consumer protections are essential. These include phasing in the enrollment to allow time to deal with problems, using multiple means to get the word out, letters, websites, calls, meetings; and perhaps most importantly, trusted community-based organizations with no financial interest inc consumer choices to educate the public.

Wisconsin uses Aging and Disability Resource Centers in this capacity and others may find it good to use Independent Living Centers, Area Agencies on Aging, and even Recovery Learning Communities which are a development

coming out of the mental health and substance use disorder community as a way to really help people get back into living normal lives.

Finally we believe it's really important to allow consumers up to 90 days to make their choice of plans before they assigned. And California is using this model for its dual demonstration.

Also important to use smart assignments which is coming to be a term used for assigning consumers based on the plan that has most of their current providers.

Next slide. So it's really also important to set up the program with as broad a range of long term services as is possible. That would include all Medicaid state plan services as well - state plan long term services as well as all waiver services for long term services. And a number of states are taking this road.

Also important to extend the coverage services to those that are needed to keep people in the community. And this may include things like an air conditioner for an apartment that would otherwise be sweltering.

And finally, since more than half of those getting long term services in some states have behavioral health needs peer support and recovery services are also an important part of the network. And finally there should be no waiting list or caps on services.

Next slide. So a diverse and robust network of providers is also essential and many states have recognized this. These providers need to be culturally and linguistically competent, accessible for people with disabilities, and trained in independent living and recovery learning philosophies. It's also critical that they be experienced in long term services and supports.

The programs need to incorporate the long established aging and disability service providers who know this population and what to do. And a few states have moved in this direction, Massachusetts in the Senior Care Options program requires the plans to contract with geriatric social service coordinators from the AAAs. And in Texas, Star Plus has required plans to enroll all current providers for three years.

As with other forms of managed care, monitoring network adequacy is also key. States are increasingly using mapping programs to track distribution of providers and using calls or visits to providers to check availability. Arizona, Tennessee, and Texas are among those who use those secret shoppers to check on the network adequacy.

States also need to ensure continuity of care for those who have been receiving long term services already. One important way is to permit consumers to continue seeing providers for at least a year even if those providers are not in the new network. California and Ohio in their duals demonstrations are going down this path.

Also, states should require the MCOs to allow individual exceptions to network rules where those are needed for the consumer's health. And again, in the duals demonstration, Massachusetts is allowing these single case exceptions.

Next slide. So I'll pause here and see if there are any questions so far, Marisa, that we should address.

Marisa Scala-Foley: All right, thank you, Alice. I've been able to take care of most of the questions but I do think there's one I'd like to pose. You touched on it really

briefly just within the past couple of minutes but it may be worth expounding on a little bit.

And this question comes from Norma, who asks if there's a role for subcontracting with managed care plans for Aging and Disability Resource Centers or other kinds of community-based organizations such as Centers for Independent Living and so forth?

Alice Dembner: Sure, that's a great question and I think absolutely there is a role for subcontracting. I think there are sort of two - two big roles I think that are - two big channels for those organizations to participate and we would argue that it's really important for them to participate to make these systems of care work.

And one would be to be actually hired directly by the state to perform some functions.

And I think the second would be to be subcontractors to the managed care companies to perform specific functions whether - and we'll talk a little bit about that in a moment, whether it's care coordination or as I mentioned earlier, is it - you know, outreach - part of the outreach and enrollment effort or as service providers since I know some of the AAAs for example serve a dual role of both being connecters to services as well as being service providers. And the same thing for the independent living centers.

Marisa Scala-Foley: Okay, so we got a question from Alexandra who asked how does Medicaid managed care integrate with current waiver-based long term services and support? Do you tend to see the same agencies or different agencies providing coordination and oversight?

Alice Dembner: Good - again, another good question. I think there are different model, different states are pursuing different models. Often when states implement managed care they often try to sometimes - what is the word I'm looking for, consolidate waivers and so there's sometimes a role where the managed care company is taking over the role of others that had in the waiver.

And then other states try to keep them separate or they keep a part of the system separate, it's quite common actually for example for developmental disability and intellectual disability long term services to be carved out and to continue as a separate waiver program.

Marisa Scala-Foley: Okay, a question from Althea, how do you see managed care organizations incorporating the services supported within participant directed waiver programs such as what you talked about earlier? Such as I think the purchase of an air conditioner for someone who may need it in order to remain at home and so forth.

Alice Dembner: Sure, and I'm going to talk a lot about that also in a little bit going forward but I think it's really important that - to incorporate those but I think there is a tension there and that's one of the things that I think states are still working through how to make that work.

Because the impetus, you know, for - not the impetus but, you know, the MO of some managed care companies is really to try to manage. And if they're - if you're - it's sort of at odds with the idea of consumer direction.

So I think figuring out how to balance that so you don't lose consumer direction which I think is a very important part of long term services and support is something that I think is still being worked through but needs to happen.

Marisa Scala-Foley: Okay, I think we've - hold on. How - another great question from Barbara who asks, how have you seen - in the states that you've looked at, how does local HUD senior housing intersect with these initiatives, particularly regarding training staff and - who are maybe new to the concept or with regard to resident or consumer input?

Alice Dembner: You know, I don't have the answer to that question. It's not something I looked at and I'm wondering if maybe in the Q&A there's someone on the call who could speak to that. Otherwise I will try to get some information and pass that through Marisa to folks.

Marisa Scala-Foley: Okay, great. And I think we've covered - I'm just scrolling back to make sure I haven't missed anything. I think we've covered just about everything we've gotten so far. We did get one question which actually provides a great segue into the next section of this presentation.

And that is that you mentioned ombudsmen and she was wondering how plans have used ombudsmen or states have used ombudsmen in relationship to managed care organizations. But maybe this is a great spot for us to move on and we can take any other questions that come in, you know, in our next Q&A segment at the end.

Alice Dembner: That would be great and if we could hold that and see if it's answered by - I'll be talking quite a bit about ombudsman later and if not please ask that specific question on ombudsman again. So shall we go on?

Marisa Scala-Foley: Yes, go right ahead.

Alice Dembner: All right, so we're going to turn now to - you know, how do you run these programs and what are some issues and problems of practices in running these programs?

So I would say one of the first things is really to make sure that the program is promoting home and community-based services. Since you know, caring for people in the least restrictive setting is a federal law under the (unintelligible) decision of the Supreme Court and that should be explicit in the contracts with the managed care companies.

And in making that explicit, states can take some of the steps that I've outlined on this slide. So for example, they can hold plans responsible - and we would argue that they should, for the full nursing facility stay of any person in the system.

And one reason that's very important is because if you have nursing facilities carved out as some programs do, you have unfortunately a perverse incentive for the plans to put people or encourage people to go into nursing facilities because then it's not on their bill. And so it's a - unfortunately works against the idea of promoting community-based services.

Secondly, states can pay plans the same whether the person is in a nursing facility or in a community. And this is called using a blended rate. And in some states, including Arizona and Tennessee, they build into that blended rate an assumption that use of nursing homes is going to go down compared to the previous year. So there's a - you know, already building in that rebalancing into the rate.

Third, require the plans to reduce waiting lists for home and community-based services as part of what they do and that's been used in a couple states to - quite well.

And finally, to really make sure that you're monitoring for any reduction in long term services and supports. And California has put that - plans to put that in place for its dual demonstration.

And we would add that there's sort of another element of that that we haven't seen in operation yet but would be important which is to ensure that the percent of spending - long term services spending in the community stays stable or increases over what it was in the fee for service system so that you are rebalancing as you're implementing the home and community-based services more.

So any of these mechanisms can be combined with federal incentive programs which can operate in fee for service or in managed care that enhance the rebalancing. And these include the money follows the person program, the balancing incentive program, and the community first choice program among others.

And several states have used - as I mentioned earlier, managed care to rebalance and in fact Tennessee effectively combined its Money Follows the Person and its managed are capitated formula to double the number of people it was serving in the community in just a few years. They still have a way to go but they have made a significant step.

Next slide, please. So another real important part of the program is that once consumers have chosen a plan that their needs and preferences are fully

assessed by someone who is knowledgeable about long term services but who will not financially benefit from the decisions made.

We believe the best practices here is to use an agency outside the MCO, for example an ADRC, a AAA, Independent Living Center. But most states permit plans to use their own staffs to do these assessments.

We think it's best to use the standardized assessment, in fact that's recommended by the balancing incentive program in - you know, federal government. A number of states are beginning to develop their own standardized statewide assessments.

Also, the assessment should be comprehensive. It should include not only the person's illnesses but their - it should include their physical and mental functional status, their quality of life goals, and their personal preferences. It should also consider socioeconomic status, accessibility of services, existing supports, and many other factors.

I would cite as an example the Washington Comprehensive Assessment Reporting Evaluation, which is also cited as a model practice in the balancing incentive program implementation model.

Finally, assessment is something you really can't do well by phone. Arizona is one of the states that not only requires in person assessments but also requires plans to initiate services within 30 days of people signing up for the plan.

And they've shown this is doable. Plans met that standard 97% of the time for people living in the community in fiscal 2010.

Next slide. So long term services work best in managed care when the services are well coordinated, especially when they're coordinated broadly with other services as I mentioned earlier.

So a promising practice here is having an independent care coordinator, someone who is conflict-free, again, not a provider or employee of the MCO. And Massachusetts expects to offer this kind of coordinator as part of the interdisciplinary team that each consumer will have in its dual demonstration.

This long term services coordinator would be chosen from a community-based organization and would help asses long term services needs, help develop an individualized care plan, and also be the liaison with service providers and the managed care company.

A new state law in fact specifies that the MCO may not have a financial interest in this community-based organization serving in this coordinator role. And that the community-based organization may not be an LTSS provider unless it is granted a waiver by the state health secretary. Of course, the details of how this will operate are still being worked out.

A second step would be to develop and follow an individualized care plan for each consumer. Fortunately many states are using this promising practice.

These care teams should have the power to authorize specific services so that they can quickly head off problems before they lead to avoidable hospitalizations or nursing home stays.

And Texas Star Plus is one of the few that empowers its coordinators with - in this way so they can authorize services without having to go back to some sort of central utilization review authority.

And finally, care coordination works best with lots of one-on-one contact. Arizona and Wisconsin require visits to consumers at least every 90 days. And I think many states would find that even more frequent contact would work better.

Next slide. So Joe's story offers an example of the problems that can occur if you don't have a point person for the care team who can quickly authorize services in that way.

Joe has dementia yet he still lives at home with his wife. She supports the two of them with her cleaning job and they depend on long term services to get - to take care of Joe while she's at work.

On a typical day the aide comes to help Joe with his morning routine and then he goes to a day program and then he gets help again from an aide in the late afternoon until his wife arrives home.

So one day this winter he woke up with what seemed like the beginning of the flu that has been going like wildfire through all our communities. Before Joe - before Joe's home stay shifted to managed care he would automatically get to stay home with an aid if he was sick. But on this day, you know, his wife also thought it would be better if he stayed home.

But the homecare agency under the new managed care program said they didn't have an MCO authorization to stay home with Joe.

So they sent him off to the daycare center. When Joe's wife tried to get authorization so this didn't keep happening she and an advocate helping her were referred back and forth over a period of more than two weeks among

five different people, including an MCO nurse coordinator, a case worker, and various MCO social workers. No one stepped up to solve the problem.

Fortunately Joe didn't infect everyone at the daycare center the days he was there sick and didn't get sicker himself. But his wife really felt this was not good care. So she switched him to another MCO and is hoping that the new plan will be more responsive.

So when shifting to managed long term services and supports it's important to have the option of consumers directing their own personal care services including hiring and firing personal care workers. Someone asked before, you know, how is this working? Well, it actually is happening in at least 12 of the 16 states that were doing managed care in 2012.

And as part of consumer directed services many of these plans are training consumers in how to oversee their own workers to help them take on this role. And also training them in how to help care for themselves. So it is working in many states despite the fact that there is this tension between who - you know, among who has the control.

If the consumer requests it we think family members should also be trained and paid to be personal care assistants. And there are at least three states that are doing that. My guess is, again, this is a growing phenomenon as people recognize this is an important role that family members can play.

Managed long term services and supports can also provide respite services to help shore up family members whether they're paid or unpaid who are serving in a caregiver role.

Next slide, please. So let's turn now to monitoring since there are many, many moving parts with one of these programs, oversight is really a critical function once the plan is open - up and running.

Next slide. So to start states should require plans to meet robust quality and performance standards. And as many of you know, national standards as under development for LTSS.

But states are moving ahead with their own measures because they need them now and some are tracking preventable hospitalizations and nursing home placements, checking whether - tracking whether there's timely assessment and implementation of care plans, and also doing consumer satisfaction surveys.

A promising practice is also to include assessment of the consumer quality of life and the degree to which service needs are being met, degree to which there are changes in functional status, whether there are disparities as a result of ethnicity or age or disability, to what extent care coordination is occurring in a positive way, and whether rebalancing is continuing.

My colleagues at the National Senior Citizens Law Center in California have just put out a guide to LTSS outcomes measures which I recommend to people to read. And I believe there may be an upcoming webinar that addresses that issue as well.

So states should also survey all consumers with an LTSS specific tool and conduct face-to-face interviews with a subset of consumers to go deeper in depth as to what's happening.

Currently there's in development a CAHPS, a consumer survey for home and community-based services, which will probably be very helpful to states in the future. In the meantime states can look to Wisconsin as one example of the breadth of measures that can be used in a quality of life survey.

Wisconsin's personal experience outcomes integrated interview and evaluation system or PEONIES, like the flower, includes questions in 12 areas including whether the consumer is living in his or her preferred setting, making his or her own decisions, working or pursuing other interests, maintaining relationships, and whether they're comfortable with their own health. The center for healthcare strategies has recognized this survey as a promising practice.

States should also incorporate these performance measures into MCO contracts and tie payments to quality using incentives or penalties. Arizona, Tennessee, and Texas are among those that do this. Texas, for example, includes a withhold, part of the capitated fee, and managed care companies can win that back if they meet certain quality standards.

Finally, to keep the public eye on quality states should publicize the details of their quality and performance assessments of MCOs in an accessible fashion for the public.

So turning to ombudsman, we think it's really important that besides the state doing direct monitoring that the state should establish and fund an independent ombudsman, preferably by contracting with an organization that is already trusted to represent consumers.

Alternatively the state could expand the role of the federally required long term care ombudsman from focusing on institutional care to including all of

long term services and supports. In Wisconsin in fact they use both methods together after consumer advocates pressed for an ombudsman during the moved to managed care.

This state contracted with disability rights Wisconsin to operate an ombudsman program for people 18 to 59 getting Medicaid long term services and supports. Ombudsman across the state handle individual cases while a program manager identifies systemic problems and has been able to secure some statewide improvements.

In addition, the state enhanced the role of its long term care ombudsman to include complaints from people 60 and older getting community-based long term services and supports in addition to institutional-based care.

For the dual demonstrations, advocacy groups including Community Catalyst, have come together to recommend a model that also includes consumer education and empowerment in addition to individual complaint resolution and identifying systemic problems.

In a paper laying out the recommendations we suggest possible designs, criteria and payment options, and discuss existing models of managed long term care and other managed care ombudsman. This document can be found on the duals democracy website listed in the resources at the end of this presentation.

Next slide. So other consumer protections that are also important include streamlined grievance and appeals, rigorous contract oversight, reducing care only with state approval, which is something that Delaware has put in place, enforcing compliance with the Americans with Disability Act, and with the federal mental health and substance use disorder parity act, and adhering to

standards for cultural and linguistic access, and finally transparency on contracts, on outcomes, and on spending and MCO rates.

And in fact, Minnesota's governor has set an example for that kind of transparency by requiring Internet posting of all contracts for managed care companies and reporting on managed care finances, reserves, provider rates, and patient outcomes on a reader-friendly website.

Next slide. So as we discussed there are many phases to implementing managed long term services and supports, which are depicted here. And I include this slide as a possible checklist for people to assess if consumers are being engaged in all of these phases.

Next slide. So my final message to you is this, proceed with caution on managed Medicaid long term services with awareness of the potential benefits and the risks. There is an opportunity for better care and control of costs but to work you need to put consumers first.

Collaboration with consumers and with stakeholders is essential as is vetting the design carefully of the program and vetting the ability of the MCOs to run the program. And finally, it's very important that states retain strong oversight over the program and not just turn it over to the managed care companies.

Thank you so much for the opportunity to share all these suggestions with you. I look forward to hearing your questions and your comments.

Marisa Scala-Foley: All right, thank you, Alice. So we have lots of time left for questions and answers and we've been getting lots of questions in through chat. So let me first go through the resources section of this slides really quickly.

As always with our webinars we have included several slides worth of resources that were both useful in terms of preparing for this webinar as well as other related links that can provide additional information on the topics we've been addressing today.

So first - on this first slide we've got several resources including the report on which this webinar was based that come from community catalyst as well as some other consumer engagement from consumer advocacy publications that they have put out.

We've also included resources from other partners, the toolkit that the disabilities right education and defense fund and the national senior citizens law center developed in looking at long term services and supports, beneficiary protections in a managed care environment, as well as the National Association of States United for Aging and Disabilities State Medicaid Reform Tracker and some other reports and frameworks that deal with managed long term services and supports and integrated care.

We've included several Kaiser Family Foundation resources. And this is probably actually a really good point for me to mention again that I'm - hopefully none of you are frantically trying to scribble down these URLs because many of them are long and complicated. We will be posting our slides on our website within the next week or so.

We'll post the slides, recording, and transcripts on our website as soon as possible. However, if you would like to get a copy of the slides sooner than that please do feel free to email us at AffordableCareAct@AOA.HHS.gov; again, that's AffordableCareAct@AOA.HHS.gov. And I'll be happy to send you a copy of the slides sooner than that if you would like.

We've included some CMS resources, resources that have been put out by their Medicare-Medicaid Coordination Office also know as the duals office as well as a resource kit that they put out related to managed long term services and supports and the report that Alice referenced earlier when she was talking about looking at that map of where managed long term services and supports had been implemented or was being developed in a number of states.

And as always, we've included some general Affordable Care Act resources in here including a link to our health reform web page which is where we store the recordings, transcripts, and slides of all of our webinars that we've done for the past couple of years.

So with that we will continue our webinar series next month and we will be looking at quality and managed long term services and supports focusing on a report that was just issued by the Disability Rights Education and Defense Fund and the National Senior Citizens Law Center looking at this topic.

We'll send out our registration in for in early to mid-February so please do watch your email for more information. We're looking at February 26, I believe, for this next webinar on quality and managed long term services and supports.

So with that I will - we've gotten several questions in through chat but I do want to give people the opportunity - who are only on the phone the opportunity to ask questions as well. So Operator, if you could remind - instruct people as to how they can queue up on the audio line to ask questions that would be great.

Coordinator: Thank you. We will now begin the question and answer session. To ask a question please press star then 1 and record your name at the prompt. Your

name is required to introduce your question. To withdraw your request press star-2. One moment please, as we wait for the first question.

Marisa Scala-Foley: All right, so while we're waiting for that first question through the audio line we got a question in from Sandy - actually we got this in from a couple of different people in the audience who asked if you could talk a little bit about - or present examples of states managed long term services and supports programs that include people with developmental disabilities because some states have been known to carve out persons with developmental disabilities.

She was wondering if you could talk about any examples from the research that you did of those that did include people with developmental and intellectual disabilities.

Alice Dembner: I will have to get back to people on that because that - I should have used a disclaimer at the beginning, that was not an area that I focused on. I deliberately did not look at how the developmental disability population was handled, not because of any disinterest but as a way to make the research manageable in a short period of time.

I think across the country many, many states have carved out the disability - the developmental disability and intellectual disability population. So I cannot offer you an example. I can get back to you on that. Or maybe there's someone else on the - in the audience who would like to address that by raising their hand.

Marisa Scala-Foley: Okay, Operator, have we gotten any questions? Anyone in the queue for the audio line?

Coordinator: I'm showing no questions at this time.

Marisa Scala-Foley: Okay, well, we'll keep going then with the questions in the chat. We got a question from Jeanette, who asks if you have any best practices or recommendations on consumer appeal rights regarding managed care organization decisions related to assessments, sort of this service authorizations? Wow, that was tough to say. And a choice of providers.

Alice Dembner: I'm sorry, could you repeat that question?

Marisa Scala-Foley: Sure, Jeanette asks if you came across any - developed any best practices or came across any best practices or had any recommendations related to consumer appeal rights regarding managed care organization - plan decisions on assessments or service authorizations or provider choices?

Alice Dembner: Yes, we do have several recommendations on that. Certainly one is that those appeal processes - processes need to be really accessible and simple and there I really cannot point to a state that has managed to do that. They're unfortunately mostly incredibly complex. It's critical that the states provide care while the appeal is pending.

And I know that that has been an issue in many states. I believe New York under its voluntary managed care system for long term services has done that but I - and I believe there is some discussion in the new dual demonstration in New York about not carrying that over into the Medicare part of the program.

So I think those are a couple of best practices that I would recommend.

Marisa Scala-Foley: Okay, we got a question in from - we got several questions related to assessment. So let's tackle a couple of those. One from Althea, who wondered

if you came across any states that looked at - within their assessments, family health or situational health?

Alice Dembner: Situational health, yes, I believe that is part of the - well, it's part of that PEONIES survey in Wisconsin and some of the plans in Wisconsin use that as part of the assessment tool, others use it only as, like, a quality control tool afterwards or a checkup.

But I believe it is included in that. And I think some of the more robust assessments that are being - processes that are being developed in New York for example, I think will include that. I'm not sure that any of the others do currently.

Marisa Scala-Foley: Okay, so some - along similar lines related to assessment, we got a question from Tom who asks about how states are assessing the cognitive abilities of participants through their assessments tools. Are they using separate tools? Are they integrated? You know, what types of tools are they using?

Because dementia could play a major role in all of this in the extent to which people can manage care or may need to rely on caregivers and so forth.

Alice Dembner: Absolutely and I think in terms of that - or sort of whether they're using - whether they're doing testing with the individual or they're using caregiver information, I think states are using a combination of those as a - you know. In reference to what the specific tool that they're using, I did not collect information at that level though I imagine it's probably available.

Marisa Scala-Foley: Okay, Darl) asks if the extent to which states are including or plans - states and plans are including day services such as adult day services and so forth

within plans given the concern that, you know, people may become isolated if they're homebound?

Alice Dembner: Right, so I - a number of plans are including day services, both because it tends to be a fairly efficient way to help provide care for people and people like the social aspect of it.

So I think there is a movement towards that and we certainly seen it in a number of the duals demonstrations that long term services component is very much including that as an option for care.

Marisa Scala-Foley: Okay, just scrolling - okay, why don't we turn back to the Operator and see if anybody else has queued up in the audio line.

Coordinator: I'm showing no questions at this time.

Marisa Scala-Foley: Okay, I am going to keep scrolling through. Okay, Bil) asks a question with regard to the extent to which you came across or any recommendations that you all may have with regard to guidelines that states should consider with regard to workforce development or training for family and paid caregivers through plans or through the state's managed long term services and support systems.

Alice Dembner: So I'm going to address those two separately unless Bill was looking at them together because I think there's certainly a big piece of workforce developing which is very critical to making these programs work because there is - you know, growing demand as I said for the services and for the most part not enough folks in the community workforce to take care of them.

And so there are a number of initiatives under way. The PHI, which is the national organization that works on issues of workforce and worker rights within this arena as a major plan that they have laid out which I would heartily recommend people take a look at for workforce development.

And some states are really experimenting with, you know, how can they encourage this development with career ladders and other efforts of that sort.

As - and actually I would just - as an aside just mention there that also very important and the person had asked earlier how HUD programs intersect with managed long term services.

And I would say that, you know, states are also trying to find ways that through the managed care system or through coordination with their own housing efforts how they can develop the affordable housing that's needed to enable people who want to live in the community to live in the community who may have lost their homes because they were living for a period of time in a nursing home or who's - you know, current homes may not be the appropriate setting for them even with supportive care.

As far as training for family caregivers, there are several states and I think - don't have the stuff memorized, I don't know if we can go back to the slide - I think we had a couple of states that were mentioned that are doing that training for family caregivers there among the 12 where personal care services include using family care members.

Marisa Scala-Foley: Go back and see if I can get to that slide right now, here we go. So we got a question - let's see, I'm just scrolling through. Any questions through the audio line, Operator, at this point?

Coordinator: I'm showing no questions at this time.

Marisa Scala-Foley: Okay, everybody's busy on chat so I'm scrolling through right now. Actually with regard to the question we had earlier related to managed long term services and individuals with intellectual disabilities and developmental disabilities, we got actually some input from our audience.

Alice Dembner: Perfect.

Marisa Scala-Foley: Yes, I know. So Allen mentions that there are managed long term services and supports programs for individuals with DD in Wisconsin, Michigan, Vermont, and Arizona through not-for-profit managed care organizations. Also North Carolina and others are emerging in other states as well. So there's the answer to that question or at least a partial question.

There are also other resources and reports that have come out looking at managed long term services and supports in individuals with disabilities - developmental disabilities and intellectual disabilities in different states.

So if the questioner wants to email us at that email address I mentioned earlier, AffordableCareAct@AOA.HHS.gov, I'm happy to send you links to some of those resources.

So I'm looking to see if there's anything else. Okay, so here's another question from Jennifer, who asks, beside respite care do states or state managed long term services and supports programs - did you come across any that included services for caregivers that might address the health and wellbeing of caregivers as part of the service packages?

Alice Dembner: I did not but I believe that there are. I think that I have since heard that there are several - you know, some states that are combing that, the respite with those kind of services. And I would refer people for the answer to that question to the National Caregivers Alliance, which I think is maybe tracking that area.

Marisa Scala-Foley: Okay, I'm looking to see if there's - I know we got one other question and I just - bear with me while I scroll up.

Okay, so we got a question from Betsy, who asks if you all had any recommendations that you would make to community-based organizations such as area agencies on aging and centers for independent living and the like as to how they can sort of - as she puts it, keeps themselves in the mix and really be relevant to - as states begin to look toward this shift to managed care?

Alice Dembner: Great question, and I would say one of the things that's really important is to - as much as possible get in on the planning phase to - you know, to talk to state officials, to talk to consumer advocates, and really to try to be at the table so that you can, you know, help be part of shaping it. So I would say that's one important thing, it's not to sort of hang back.

The second I would think is really important to demonstrate through whatever means you have possible whether previous reports or a presenting consumer stories to the skills and that - you know, what you do have to bring to the table.

And finally, to look at, you know, a number of the states that really have gone out of their way to incorporate community-based organizations into these

programs then to highlight those examples for the folks in your state who may not be aware.

And finally I would say I think some of the associations of various types of community-based organizations have been getting very much involved in this. And so, you know, if you're not already a member of one of those organizations for whatever type of community-based organization you are you might to look to see if they're engaging in a way that could help you.

Marisa Scala-Foley: And that's a great - actually segue into talking a little bit about, you know, certainly we've been - the administration for community living has been addressing issues related to managed long term services and supports through this webinar series as you've heard today and hopefully you heard on previous webinars last year.

But we've also funded - provided some funding to three national organizations, the National Association of Area Agencies on Aging, the National Association of States United for Aging and Disability - Aging and Disabilities, and Boston University to provide some training and technical assistance related to building the business capacity of community - of aging and disability community-based organizations. Although NASUAD will be targeting state organizations and how they fit into this mix.

But n4a and Boston University will be looking at building the business acumen of community-based organizations in order to sort of play a role in this new managed care - in this new managed care world that we're living in when it comes to long term services and support.

So there will be more on that coming out in the coming weeks and months but that is something we're also looking to address as well in some of the technical assistance that we provide for our partners.

Okay.

Alice Dembner: And Marisa, if I could add one thing, I just saw in the last couple of days that SAMSHA, the mental health (unintelligible) agency, also just put out a grant announcement for grants to - I believe, state-based organizations working in those arenas to - at the community level to try to do the same kind of thing.

Marisa Scala-Foley: Yes, for those - if there are any organizations that are behavioral health organizations that are on this webinar, SAMSHA's becoming very active on this front.

They have what is known as their BH Business, Behavioral Health Business Initiative, which is looking to form learning networks that are focused on targeted issues related to building the business capacity of community-based organizations to participate in health reform efforts.

For those of you who may be interested in that, your primary mission does need to be behavioral health oriented but feel free to email us at AffordableCareAct@AOA.HHS.gov and I can provide you with a link to that effort. I believe the applications are due next week so there's not a lot of time on that but I can send you a - I can certainly provide you with a link to that effort if anyone is interested.

Okay, so let's see. Operator, any questions through the audio line?

Coordinator: There are no questions at this time.

Marisa Scala-Foley: Okay, we got one more question in from Robin who asks - I know you touched on this a little bit, Alice, as you were talking about promoting home and community-based services but if you could maybe go into a little bit more depth about what states are doing with regard to - or how money follows the person and nursing home transitions sort of fit into state managed long term services and supports program?

I know you touched on it in the example a little bit in your slides.

Alice Dembner: Sure, so I think a number of states are looking really to try to dovetail the two approaches because, you know, it's - you know, particularly important where states have had such an institutional bias to their programs to figure out constructive ways to help people move back into the community.

And that can be really challenging within a managed care environment where you have a capitated fee, where do you find the money to help people make that transition to provide them with the funds they may need for first month's rent or to - you know, help them, you know, set up a, you know - whether it's apartment or a unit in assisted living, etc.

And those are the things that the money follows the person funds can be used for very effectively. So it's really trying to couple those. And I don't have the list of states in front me that are doing that but as I mentioned, Tennessee had really effectively done that and I know there are a number of other states who are doing very similar things.

And there might be someone on the call who has that list or a few other states in mind and we would love to hear from you if there is someone who knows some of the other states off the top of their head.

Marisa Scala-Foley: I believe that may have been mentioned in the Truven report that you had reference earlier when we put up the map early on in your slides, I think they talk about that as well and they have a listing of states that are doing some of that work.

Do you - just from what you do know about that - the work that states are doing related to money follows the person and managed long term services and support, is it the plans that are handling - the managed care organizations that are handling those transitions?

Or are they looking toward community organizations to continue to do that work that may have been started under MFP?

Alice Dembner: I think there's a mix is what I understood and looking at it, you know, some cases - you know, the role of managed care companies in this - all of this things varies greatly from state to state and there are - some states a state is really asking the managed care company to take that on. Where in another state they're continuing the other way.

And thank you for pointing out that the Truven report did look at that issue and I think might have some information on that question as well, Marisa.

Marisa Scala-Foley: Okay, great. Operator, one last call for any questions that may have come up on the audio line?

Coordinator: There are no questions at this time.

Marisa Scala-Foley: All right, well, I think we have covered all of the questions that came in via chat so with that I will - I want to say thank you to Alice for a wonderful,

thought-provoking presentation and thank you to our audience for such terrific questions. They've been sort of coming in fast and furious throughout the course of this webinar.

So if anyone on the webinar thinks of any additional questions or if you have suggestions for future webinar topics, particularly related to integrated care and managed long term services and supports, we very much want to hear from you. So please do email us - and I'll repeat this email address one last time at AffordableCareAct@AOA.HHS.gov.

We very much want these webinars to be as useful to you as possible so we do welcome your suggestions. We thank you all for joining us today and we look forward to having you with us on future webinars. Thank you very much.

Coordinator: That concludes today's conference. You may now disconnect.

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